Patient Questionnaire

Name:_____ Age:_____ Date of Birth:_____ Date:_____

What is the reason for your visit?_____

What prescription or over-the-counter medications do you take on a regular basis?_____

_____

Please indicate (X) if you or an immediate family member (specify who) have now or in the past had any of the following:

	You	Family Member		You	Family Member
Anemia/Blood Prob.	☐		Cancer	☐	
Bladder Infections	☐		Heart Disease/Attack	☐	
Blood Clots/Phlebitis	☐		Sexually Transmitted Disease	☐	
Breast Disease	☐		Urine Incontinence	☐	

Since your last examination, have you had any problems with:	**Yes**	**No**
Your menstrual cycle?	☐	☐
Irregular Bleeding?	☐	☐
Cramps with your period?	☐	☐
Abnormal vaginal discharge?	☐	☐
Pelvic/abdominal pain?	☐	☐
Breasts?	☐	☐
PMS?	☐	☐
Any urinary or bowel problems, burning, frequency, loss of urine, loss of stool?	☐	☐
Concerns with the appearance of your skin or unwanted hair?	☐	☐
Since your last visit, have you had any:	**Yes**	**No**
Medical Problems?	☐	☐
Sexual Problems?	☐	☐
Surgeries?	☐	☐
Change in family history?	☐	☐
Are you currently:	**Yes**	**No**
Allergic to any medication? Identify:	☐	☐
Allergic to Latex?	☐	☐
Using any type of birth control? Identify	☐	☐
Please indicate:	☐	☐

Age of 1st period: Cycle Length: # of bleeding days: Last Menstrual Period:

# of pregnancies: # of Deliveries: # of miscarriages:

Date of last Pap Test: / / Date of last Mammogram: / /

Do you:	**Yes**	**No**
Smoke? # Years? Cigarettes per day?	☐	☐
Drink alcohol? Drinks per day? Per week?	☐	☐
Use recreational drugs? Type?	☐	☐
Exercise? Type? How often?	☐	☐
Have caffeine? Type? How much?	☐	☐
Perform self-breast exams? How often?	☐	☐
Use Vitamin/Mineral supplements? How much?	☐	☐
Get Calcium in your diet? How?	☐	☐
Are you exposed to health hazards at home or work?	☐	☐
Have you ever been sexually abused, threatened or hurt by anyone?	☐	☐
What Pharmacy do you use?		

Primary Care Physician:	Patient Signature:
Date reviewed with patient	Provider Signature: